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Hôpital St-Boniface Hospital
[redacted for public archive]

AMBULATORY CARE SERVICE
MENTAL HEALTH PROGRAM
[redacted for public archive
January 26, 2015

Ms. D. Wright
Brief Treatment Services
[redacted for public archive]

COPY

Dear Ms. Wright:

RE: Ms B [Name redacted for public archive

Thank you for referral of Ms. B [redacted for public archive]
, whom I saw in assessment through the Psychiatric Urgent Referral Clinic on January 22, 2015. She set out a ten year history of symptoms of Posttraumatic Stress Disorder. These related to a domestic assault by her ex-partner in which she feared for her life. Symptoms have included avoidance of places and situations that bring up memories related to the assault, flashbacks, insomnia, tension, jitteriness, and labile anxiety with fight-or-flight physical symptoms in the face of everyday stresses, and flashbacks to the assault. Transient thoughts of suicide sometimes accompany anxiety exacerbations, but never any consistent wish or intent. [redacted for public archive] did not endorse sustained dysphoria, lethargy, anhedonia, pessimism, or other symptoms of depression over and above this baseline presentation. Similarly, there is no recent or remote history of mania or psychosis.

Originally, Ms. B [redacted for public archive] was referred to Dr. L. Schwartzman for psychotherapy through the Victims of Crime Program. She felt that the cognitive behavioral work she had done was of partial benefit to her sense of safety, self-esteem, and ability to cope, although the symptoms persisted. Funding for the sessions came to an end sooner than expected because her ex was ultimately acquitted at trial of the various charges that he faced. She continues to maintain and value the therapeutic relationship with Dr. Schwartzman, but is only able to afford to see her two or three times a year. She is hoping to find

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more regular counseling support through Aulneau Centre, for which she was recently given an appointment.

I had Ms. B [redacted for public archive] sign consent for release of information regarding the care she has received from Dr. Schwartzman. The collateral history she provided was compatible with the above, instead of a long-term and broad-based history of maladaptive coping and emotional dysregulation.

For most of the course of the above-noted diagnosis, Ms. B [redacted for public archive] has not taken prescription medications. Last year, she was prescribed a trial of citalopram, but found that if anything it made her anxiety paradoxically worse. A subsequent trial of paroxetine 20 mg once daily has caused sedation as a side effect, although this is diminishing with continued use. In the last couple of weeks, she has seen some modest gains in day-to-day anxiety and physical tension.

Past medical history is significant for asthma managed by Ventolin, endometriosis that eventually required hysterectomy and oophorectomy, and osteoarthritis secondary to old physical trauma. Beside the paroxetine, Ms. B [redacted for public archive]
takes an estrogen supplement by patch, and a Ventolin inhaler. She uses no herbal products. There is no history of alcohol intake, and she eliminated the use of caffeine. Ms. B [redacted for public archive] used to use cannabis, but no longer does so. Family history is positive for alcohol abuse in her mother.

As mentioned in your chart notes, Ms. [redacted for public archive] has a previous history of physical abuse from her step-father. She professed a hazy recollection for much of her childhood on that basis. However, she did note good lifelong relationships with her grandparents, who bore much of the responsibility for raising her. She is trying to return the favor by helping them in their old age now. Ms. B description of her emotional and functional status in her twenties and early thirties actually was unremarkable. She indicated a productive work life, good relationships with friends, and basically intact emotional health during that timeframe. All of the above started to deteriorate when a romantic relationship with a new partner turned physically abusive, eventually leading to the events described in the first paragraph.

On mental status examination, Ms. B [redacted for public archive] presented as well-kempt and groomed, casually attired Caucasian female, who appeared roughly her stated age. Posture was normal, good eye contact was made, and range of motion was full and spontaneous, with no motor agitation or retardation, and no involuntary movements. Speech was

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normal in rate, tone, volume, and spontaneity, with no pressure or response latency. Prevailing affect was euthymic, though there was reasonable range and responsiveness appropriate to the content of conversation. No sign of disproportionate lability, irritability, or incongruity was seen. No response to internal stimuli occurred during the interview. Thought process was occasionally circumstantial, but never tangential or loose. Examination of thought content was negative for delusions, aggression, and suicidal thought. Cognition was not formally tested, but appeared intact. No immediate impairment in judgment in any realm was observed, and reasonable insight was present.

I agree with the prevailing diagnosis of Posttraumatic Stress Disorder. A single cross-sectional interview admittedly is a bit limited in its ability to delineate longitudinal personality functioning, but based on the material elicited today and collateral history there is no support lent to a premorbid Cluster B diagnosis.

I agree with the current plan for increasing the availability of individual psychotherapeutic supports, rather than a group program that Ms. B [redacted for public archive] likely will find less applicable to her individual pathology. If the resources through Aulneau Centre ultimately are deemed unsuitable, you could direct her to any other psychotherapeutic service you deem worthwhile, or one from the attached list. Of course, some organizations on this list would be syndromally inappropriate to her needs, but others might be able to provide appropriate cognitive and behavioral supports at limited or no cost. In a similar vein, the WRHA's Clinical Health Psychology Program maintains psychotherapy services for which no fee is charged (http://www.wrha.mb.ca/prog/psychology/files/Psych_ReferralForm.pdf), but my understanding is that the waiting list for services is very extensive.

The trial of paroxetine to try to provide partial symptomatic improvement is a very reasonable idea. Relative to patients taking SSRI's or similar antidepressants for uncomplicated depression, individuals using them to manage an anxiety disorder are more likely to require:

1. Longer-than-average acute treatment trials in order to determine effectiveness: eight to twelve weeks at average or greater doses, instead of the usual four to six.
2. Gradual titration of the dose into the upper end of the therapeutic range in order to see the greatest amount of therapeutic benefit.

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3. In the absence of effect cognitive behavioral therapy, long-term maintenance measured in years in order to reduce the risk of symptomatic recurrence, instead of the usual six to twelve months.

As a result, if Ms. B [redacted for public archive] is tolerating the current dose of paroxetine well, without evidence of swift and dramatic benefit, it would be reasonable to slowly titrate the dose by 10 mg increments. While the average dose range for this medication is 20 to 40 mg per

day, some individuals using it to treat an anxiety disorder such as PTSD will tolerate and require up to 60 mg per day. If the medication is poorly tolerated, or if Ms. B [redacted for public archive] is dissatisfied with the degree of benefit she gets from it, she could taper it by 10 mg decrements every one to two weeks after the above trial, while simultaneously substituting a comparative agent. Reasonable candidates could include fluoxetine (initial dose 10 mg a.m., usual dose range 20 to 40 mg once daily, maximum 80 mg per day), fluvoxamine (initial dose 25 to 50 mg once daily, usual therapeutic dose 50 to 100 mg once daily, maximum 300 mg per day), or venlafaxine XR (initial dose 37.5 mg once daily, usual dose range 150 to 225 mg once daily, maximum 375 mg per day, monitor blood pressure occasionally). Rare risks of paradoxical emotional worsening and easy bruising/bleeding should be discussed in advance. The most common side effects of these medications, headache and GI upset, tend to be self-limited, disappearing within one to two weeks of initiation or dose increase. Sexual dysfunction, tremor, and sweating are less common, but can be more persistent if they do occur. Usually, this will indicate either judicious dose reduction, or switching to an alternate agent. However, if both of these options are perceived as highly undesirable due to very robust therapeutic effect, a low-dose adjunct to manage them could be entertained. Examples include cyproheptadine 4 to 32 mg per day for anorgasmia [redacted for public archive], or clonidine 0.05 to 0.3 mg BID for sweating unresponsive to conservative measures.

While a majority of patients will prefer monotherapy to achieve partial symptomatic improvement in PTSD, a minority of individuals with substantial functional impairment will tolerate and profit from adjunctive management. At present, the best documented antidepressant augmentor in PTSD is the atypical antipsychotic risperidone, at doses ranging between 0.5 and 2 mg HS. Rare risks to be discussed in advance include NMS, dystonic reaction, TD, and metabolic complications. If the medication is effective enough to retain for long-term use, these should be screened for by a fasting blood sugar every three months for the first year, and then annually thereafter along with a fasting lipid profile and performance of the Abnormal Involuntary Movement Scale (http://www.cqaimh.org/pdf/tool_aims.pdf). Elevation on the latter of any single

scoring item by 2 or more, or of the total score into the 4 to 7 range, suggests the possibility of emerging tardive dyskinesia. This would indicate either referral to a psychiatrist or neurologist for further assessment, discontinuation of the medication, or both. Common side effects from risperidone include sedation, weight gain, dizziness, hyperprolactinemic symptoms, and neuromuscular adverse effects such as pseudoparkinsonism or akathisia. For individuals who find this side effect profile unappealing or intolerable, there is a smaller but nevertheless controlled evidence base for topiramate in difficult-to-treat PTSD. Rare risks that should be discussed include kidney stone, acute glaucoma, and metabolic acidosis. Bicarbonate levels should be check annually as long as the medication is prescribed. Topiramate's side effect profile is more narrow than most of the other medications described above, with sedation and cognitive dulling the only ones in any way common. The degree of them, though, can be striking, so it is

wisest to begin the medication at a low dose and titrate it slowly. A common schedule for this is to start at 25 mg HS, and then increase by 25 mg steps every one to two weeks thereafter. While topiramate has a very broad dose range, for this indication the most common therapeutic dose lies between 100 and 200 mg HS.

I hope this information is of use to you in your and Dr. Grobler's management of Ms. B [redacted for public archive] care. Please feel free to contact my office at [redacted for public archive] if you have any questions regarding my impression or management recommendations.

Yours sincerely,

[Signature]

K. M. O'Keeffe, M.D., FRCPC*
Department of Psychiatry

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cc Psychiatric Urgent Referral Clinic by emailed PDF
Dr. W. P. Grobler, [redacted for public archive]

Dr. L. Schwartzman [redacted for public archive]